Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SOUTH TEXAS HEALTH SYSTEM
3255 W PIONEER PKWY
PANTEGO TX 76013-4620

Respondent Name
TPCIGA FOR EMPLOYERS CASUALTY COMPANY

Carrier's Austin Representative Box
Box Number 50

MFDR Tracking Number
M4-10-4468-01

MFDR Date Received
June 22, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Per the new fee schedule this account qualifies for an Outlier payment . . . The correct allowable due is $51,125.46, minus their payment of $21,140.07 there is still an outstanding balance of $29,075.39."

Amount in Dispute: $29,075.39

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The PPO discount in the amount of $24,410.32 has been process to be reimbursed to the requestor. This brings the total payment to date to $45,550.39, which is 100% of the fee schedule allowance."

Response Submitted by: Texas Property & Casualty Insurance Guaranty association, 9120 Burnet Road, Austin, Texas 78758

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 23, 2009 to July 27, 2009	Outpatient Hospital Services	$29,075.39	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, sets out the reimbursement guidelines for professional medical services.

4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 881 –THIS ITEM IS AN INTEGRAL PART OF AN EMERGENCY ROOM VISIT OR SURGICAL PROCEDURE AND IS THEREFORE INCLUDED IN THE REIMBURSEMENT FOR THE FACILITY/APC RATE.
   - 97 – THE BENEFIT FOR THIS SERVICE IS INCLUDED IN THE PAYMENT/ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE THAT HAS ALREADY BEEN ADJUDICATED.
   - 785 – ITEMS AND/OR SERVICES ARE PACKAGED INTO APC RATE. THEREFORE THERE IS NO SEPARATE APC PAYMENT.
   - 222 – CHARGE EXCEEDS FEE SCHEDULE ALLOWANCE
   - 45 – CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT.
   - W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - P32 – A FIRST HEALTH OWNED PPO NETWORK CONTRACT DISCOUNT WAS APPLIED. FOR PPO CONTRACT QUESTIONS. PLEASE CALL (800) 937-6824.
   - 773 – REIMBURSEMENT IS IN ACCORDANCE WITH THE TDI WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT AND GUIDELINES.
   - 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - W3 – ADDITIONAL PAYMENT MADE ON APPEAL/RECONSIDERATION.

Issues

1. Are the disputed services subject to a contracted fee arrangement between the parties to this dispute?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

Findings

1. The insurance carrier denied or reduced disputed services with reason codes 45 – "CHARGE EXCEEDS FEE SCHEDULE/MAXIMUM ALLOWABLE OR CONTRACTED/LEGISLATED FEE ARRANGEMENT" and P32 – "A FIRST HEALTH OWNED PPO NETWORK CONTRACT DISCOUNT WAS APPLIED. FOR PPO CONTRACT QUESTIONS. PLEASE CALL (800) 937-6824." Both parties to this dispute agree that under the contractual fee arrangement, the fee amount to be determined is the amount payable under the Texas Department of Insurance, Division of Workers' Compensation fee guidelines. Therefore, the services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables was not requested.

3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published annually in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:

   - Procedure code C1767 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

   - Procedure code C1778 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 36415 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $3.00. 125% of this amount is $3.75. The recommended payment is $3.75.

- Procedure code 85002 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $6.57. 125% of this amount is $8.21. The recommended payment is $8.21.

- Procedure code 85025 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.35. 125% of this amount is $14.19. The recommended payment is $14.19.

- Procedure code 85610 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $5.74. 125% of this amount is $7.17. The recommended payment is $7.17.

- Procedure code 85730 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $8.76. 125% of this amount is $10.95. The recommended payment is $10.95.

- Procedure code 87086 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $11.79. 125% of this amount is $14.74. The recommended payment is $14.74.

- Procedure code 81001 has a status indicator of A, which denotes services paid under a fee schedule or payment system other than OPPS. Per 28 Texas Administrative Code §134.403(h), for outpatient services for which Medicare reimburses using fee schedules other than OPPS, reimbursement is made using the applicable Division fee guideline in effect for that service on the date the service was provided. Facility payment for the technical component of this service is calculated according to the Medical Fee Guideline for Professional Services, §134.203(e)(1). The fee listed for this code in the Medicare Clinical Fee Schedule is $4.63. 125% of this amount is $5.79. The recommended payment is $5.79.

- Procedure code 77003 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code 63685 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0222, which, per OPPS Addendum A, has a payment rate of $15,566.65. This amount multiplied by 60% yields an unadjusted labor-related amount of $9,339.99. This amount multiplied by the annual wage

index for this facility of 0.9053 yields an adjusted labor-related amount of $8,455.49. The non-labor related portion is 40% of the APC rate or $6,226.66. The sum of the labor and non-labor related amounts is $14,682.15. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.1467. This ratio multiplied by the billed charge of $27,707.00 yields a cost of $4,064.62. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $14,682.15 divided by the sum of all APC payments is 64.62%. The sum of all packaged costs is $15,849.55. The allocated portion of packaged costs is $10,242.29. This amount added to the service cost yields a total cost of $14,306.91. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $14,682.15. This amount multiplied by 200% yields a MAR of $29,364.30.

- Procedure code 63650 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,206.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,523.87. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $2,284.86. The non-labor related portion is 40% of the APC rate or $1,682.58. The sum of the labor and non-labor related amounts is $3,967.44. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.1467. This ratio multiplied by the billed charge of $0.00 yields a cost of $0.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,967.44 divided by the sum of all APC payments is 17.46%. The sum of all packaged costs is $15,849.55. The allocated portion of packaged costs is $2,767.69. This amount added to the service cost yields a total cost of $2,767.69. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $3,967.44. This amount multiplied by 200% yields a MAR of $7,934.88.

- Procedure code 63650 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0040, which, per OPPS Addendum A, has a payment rate of $4,206.45. This amount multiplied by 60% yields an unadjusted labor-related amount of $2,523.87. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $2,284.86. The non-labor related portion is 40% of the APC rate or $1,682.58. The sum of the labor and non-labor related amounts is $3,967.44. If the total cost for a service exceeds 1.75 times the OPPS payment and also exceeds the annual fixed-dollar threshold of $1,800, the outlier payment is 50% of the amount by which the cost exceeds 1.75 times the OPPS payment. Per the OPPS Facility-Specific Impacts file, CMS lists the cost-to-charge ratio for this provider as 0.1467. This ratio multiplied by the billed charge of $0.00 yields a cost of $0.00. The total cost of all packaged items is allocated proportionately across all separately paid OPPS services based on the percentage of the total APC payment. The APC payment for this service of $3,967.44 divided by the sum of all APC payments is 17.46%. The sum of all packaged costs is $15,849.55. The allocated portion of packaged costs is $2,767.69. This amount added to the service cost yields a total cost of $2,767.69. The cost of this service exceeds the annual fixed-dollar threshold of $1,800. The amount by which the cost exceeds 1.75 times the OPPS payment is $0.00. The total APC payment for this service, including outliers, is $3,967.44. This amount multiplied by 200% yields a MAR of $7,934.88.

- Procedure code 95971 has a status indicator of S, which denotes a significant procedure not subject to multiple procedure discounting, paid under OPPS with separate APC payment. This service is classified under APC 0692, which, per OPPS Addendum A, has a payment rate of $109.24. This amount multiplied by 60% yields an unadjusted labor-related amount of $65.54. This amount multiplied by the annual wage index for this facility of 0.9053 yields an adjusted labor-related amount of $59.33. The non-labor related portion is 40% of the APC rate or $43.70. The sum of the labor and non-labor related amounts is $103.03. The cost of this service does not exceed the annual fixed-dollar threshold of $1,800. The outlier payment amount is $0. The total APC payment for this service, including outliers, is $103.03. This amount multiplied by 200% yields a MAR of $206.06.

- Procedure code J0690 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J2250 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code J3010 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Procedure code Q9967 has a status indicator of N, which denotes packaged items and services with no separate APC payment; payment is packaged into payment for other services, including outliers.

- Per Medicare policy, procedure code 93005 is unbundled from procedure code 63650 billed on the same date of service. Per Medicare policy, payment for this service is included in the payment for the primary procedure. A modifier is allowed in order to differentiate between the services provided. Separate payment for the services billed may be justified if a modifier is used appropriately. Although the provider billed the service with an allowable modifier, review of the submitted documentation finds that the modifier is not supported. Separate payment is not recommended.

4. As stated above, according to the submitted contract, reimbursement for the services in dispute shall be the lesser of the Agreement rate [73% of billed charges], billed charges, or 100% of the amount payable under guidelines established under any State law or regulation pertaining to health care services rendered for occupationally ill/injured employees." The billed charges were $132,016.40. 73% of this amount is $99,827.87. The recommended payment under Division fee guidelines is $45,504.92. This is the lesser amount. Therefore, the total recommended payment for the services in dispute is $45,504.92. This amount less the amount previously paid by the insurance carrier of $45,550.39 leaves an amount due to the requestor of $0.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

	Grayson Richardson	September 20, 2012
Signature	Medical Fee Dispute Resolution Officer	Date
		September 20, 2012
Signature	Medical Fee Dispute Resolution Manager	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.